EPI-LOG

Communicable Disease and Epidemiology News

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Influenza A

Three culture confirmed cases of influenza A (H3N2) in King County residents have occurred since mid-September. This is the earliest culture confirmed influenza A activity detected through our sentinel providers influenza surveillance system since 1988. Neither the Washington State Department of Health (DOH) nor the Centers for Disease Control and Prevention (CDC) are reporting unusual levels of flu activity at this time or new or more virulent strains, despite media reports to the contrary. Previously reported influenza outbreaks among travelers to Alaska and the Yukon territories during the past two summers were largely confined to visitors to that area. According to the CDC, sporadic reports of summertime influenza cases and isolated nursing home outbreaks from other areas of the U.S are not indicative of an early influenza season. However, national (and local) sentinel provider influenza reporting is only now beginning and no standardized surveillance is in place for summertime influenza. Although anecdotal reports and reports of non-culture confirmed cases suggest we may be in store for an early flu season, we will have a much better indication of influenza activity in the coming weeks as national surveillance activities begin.

October through mid-November is the standard recommendation for the *optimal* time to receive influenza vaccine to obtain protection throughout the typical influenza season. This year, persons at high risk for influenza should consider being vaccinated earlier in this time frame. Public Health - Seattle & King County (PHSKC) began administering influenza vaccine October 11th. The 1999-2000 trivalent influenza season vaccine includes A/Beijing/262/95-like (H1N1), A/Sydney/5/97-like (H3N2), and B/Beijing/184-93-like antigens. For the B/Beijing/184-93-like antigen, U.S. manufacturers used the antigenically equivalent B/Yamanashi/166/98 virus because of its growth properties and because it is representative of currently circulating B viruses.

The following groups are at highest risk for influenza-related complications and should be vaccinated: 1) persons aged 65 years or older; 2) persons older than 6 months of age who have a chronic illness; 3) children and teenagers (6 months-18 years of age) receiving long-term aspirin therapy; 4) residents and staff of long-term care facilities including nursing and rehab facilities; 5) pregnant women who will be at least 14 weeks gestation during the flu season; 6) HIV-infected persons without AIDS and HIV-infected persons with *minimal* AIDS-related symptoms; 7) *household members* of persons in any of the above categories; and 8) health care workers including physicians, nurses and other staff of clinics, hospitals and long term care facilities who have patient or client contact should be immunized to prevent infecting susceptible persons.

Influenza vaccine should **not** be administered to children younger than 6 months of age, people who have *anaphylactic* reactions after eating eggs, and adults and children with acute febrile illnesses (until their symptoms have abated).

The 1999-2000 Influenza Vaccine Information Statement (VIS) may be ordered from the DOH Immunization Program Warehouse by calling (360) 664-8797 or faxing your request to (360) 664-2929. You can also download translations of both Influenza and Pneumococcal VISs from the Immunization Action Coalition: http://www.immunize.org. The VISs have been translated into Spanish, Cambodian, Hmong, Vietnamese, Laotian, Russian and Somali.

For more information on influenza see: http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00057028.htm.

New Drug

Zanamivir is a newly approved drug for treatment of influenza A and B infection. The drug is the first FDA approved neuraminidase inhibitor, which blocks the replication of influenza viruses. Unlike amantadine and rimantidine, zanamivir is effective against influenza A and B, has no recognized significant systemic side effects, and has not been shown to cause the development of resistant virus in immunocompetent patients.

Clinical experience with neuraminidase inhibitors is limited. Published data show zanamivir to be effective in shortening the duration and severity of culture confirmed influenza infection by one to three days when treatment is initiated within 30-36 hours of symptom onset. One unpublished study suggests that zanamivir may be particularly effective in reducing symptoms and in decreasing antibiotic use resulting from influenza-related complications in high-risk persons. Another study (Monteo AS, et al. *JAMA* 1999 Jul 7;282(1):31-5) suggests zanamivir taken for four weeks is effective in prevention of influenza among healthy adults. However, *the drug is not approved for use in prevention of influenza at this time*. Zanamivir is given by inhalation twice daily for five days and acts directly at the site of virus infection with no significant systemic absorption. The drug has the potential to induce bronchospasm in persons with underlying obstructive pulmonary disease or asthma; the prescribing information should be reviewed before administration of the drug to such persons. The wholesale cost for a five-day treatment is about $44.00. A second oral neuraminidase inhibitor, oseltamivir, is not yet approved by FDA.

Zanamivir and other drugs to treat influenza should not be considered alternatives to influenza vaccination, which remains the best means of protection. The utility of these drugs in the general population will be limited by the need to initiate treatment rapidly

after symptom onset, the need for reliable, rapid diagnostic testing to confirm influenza infection, and cost of the drug. Zanamivir may be especially useful in the treatment of high-risk persons with confirmed influenza, including use in influenza outbreaks in nursing homes and other institutional settings.

NYC Outbreak

An outbreak of arboviral encephalitis due to a previously unrecognized virus in the Western Hemisphere began in New York City (NYC) this summer. The causative virus has still not been definitively identified but it is closely related to West Nile virus in the flavivirus family. The virus is maintained in avian species and cycles between birds and mosquitoes, occasionally infecting humans. The NYC outbreak was accompanied by a bird die-off that has extended at least 140 miles from NYC.

Although the epidemic in New York has waned with the end of mosquito season, with no new cases reported since September 17th, clinicians should obtain a thorough travel history from persons presenting with meningoencephalitis and consider this diagnosis in persons who visited New York this summer in the 4-21 days preceding illness onset. Viral encephalitis is reportable in Washington State, although reporting is unfortunately not very complete. Cases of encephalitis, especially of unexplained etiology in persons who have traveled to NYC over the past summer, should be reported to Public Health.

This outbreak might serve as a clarion call regarding the introduction and spread of new communicable diseases in susceptible populations. Our status as a major portal for international travel makes it a real possibility that unusual infectious agents could be introduced from abroad into our community. This outbreak is a good example of the potential utility of community-based syndromic surveillance systems designed to detect increases in the number of persons presenting with unusual syndromes such as encephalitis early in an epidemic. A method to detect and report unusual illness among wild and domestic animals clearly has value as well. Until such surveillance systems are widely available, alert clinicians and laboratory personnel are the best means of detecting outbreaks in the community. Please do not hesitate to call our Communicable Disease Epidemiology program 24 hours a day to report any unusual cluster or episode of disease in Seattle-King County.

HIV Reporting

After over a year of public debate and consideration, the Washington State Board of Health implemented HIV reporting effective September 1, 1999. Previously, only cases of AIDS or symptomatic HIV infection were reportable. With this requirement, Washington joins 33 other states that report all stages of HIV infection. Washington's system of HIV reporting is unique in that reporting is by name to local health departments, but patient name is converted to a non-name code within 90 days of receipt of a complete case report. Most states use standard name reporting while a few states have providers create a patient identifier code. In Washington, health care providers have the primary responsibility for reporting HIV and AIDS and should report cases within 7 days of diagnosis. Supplemental laboratory reporting of confirmed positive HIV antibody and viral load test results and of low CD4 T-lymphocyte counts helps to insure the completeness of reporting. Anonymous HIV testing remains widely available and results of tests conducted anonymously should not be reported. Providers who need more information about the new requirements or a supply of reporting forms should contact PHSKC HIV/AIDS Epidemiology Program at 206-296-4645 or e-mail epidemiologists Susan Barkan (susan.barkan@metrokc.gov) or Sharon Hopkins (sharon.hopkins@metrokc.gov).

Report:	**(area code 206)**
AIDS	**296-4645**
Communicable Disease	**296-4774**
STDs	**731-3954**
Tuberculosis	**731-4579**
24-hr CD Report Line	**296-4782**
24-hr CD Fax Line	**296-4803**
After hours	**682-7321**
Hotlines:	
CD Hotline	**296-4949**
HIV/STD Hotline	**205-STDS**

REPORTED CASES OF SELECTED DISEASES SEATTLE-KING COUNTY 1999

	CASES REPORTED IN SEPTEMBER		CASES REPORTED THROUGH SEPTEMBER	
	1999	1998	1999	1998
VACCINE-PREVENTABLE DISEASES				
Mumps	0	0	1	2
Measles	0	0	1	0
Pertussis	27	21	423	132
Rubella	0	0	2	1
SEXUALLY TRANSMITTED DISEASES				
Syphilis	8	3	61	30
Gonorrhea	84	100	683	768
Chlamydial infections	336	358	2848	2694
Herpes, genital	57	55	500	517
Pelvic Inflammatory Disease	31	24	208	184
Syphilis, late	2	5	31	26
ENTERIC DISEASES				
Giardiasis	30	33	152	187
Salmonella	20	20	235	166
Shigellosis	13	5	44	71
Campylobacter	29	14	221	183
E.coli O157:H7	7	7	33	26
HEPATITIS				
Hepatitis A	18	11	138	348
Hepatitis B	4	3	28	43
Hepatitis C/non-A, non-B	1	0	6	5
AIDS	18	18	162	186
TUBERCULOSIS	13	06	78	82
MENINGITIS/INVASIVE DISEASE				
Haemophilus influenzae	0	0	1	1
Meningococcal disease	1	1	18	13